Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 28, 2020	2020_738753_0001	021021-19, 021457-19, 021535-19, 021881-19, 022391-19	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

Long-Term Care Home/Foyer de soins de longue durée

The Village of Riverside Glen
60 Woodlawn Road East GUELPH ON N1H 8M8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

KATHERINE ADAMSKI (753)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 2-3, 6-10, 13-15, 2020.

The following intake was completed during this inspection:
Log #021021-19, #021535-19 related to alleged abuse
Log #021457-19, # 022391-19 related to care provision
Log #021881-19 related to falls prevention

PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s. 6(7), identified in a concurrent inspection #2020_738753_0002 (Log #024055-19) was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Director of Programs for Active Living (DPAL), Exercise Therapist (ET), Neighborhood Coordinator (NC), Registered Nurses (RN), Registered Practical Nurses (RPN), Residents, and Personal Support Workers (PSW).

The inspector also conducted a tour of the home and made observations of residents, activities, and care. Relevant policies and procedures, as well as clinical records and plans of are for identified residents were reviewed.

This inspection was conducted concurrently with Complaint Incident Inspection #2020_738753_002.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
2 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that care set out in the plan of care was provided to resident #008 as specified in the plan.

a) A Critical Incident System (CIS) report was submitted to the Director related to resident #008 sustaining an injury.

Record review of the resident's Minimum Data Set (MDS), showed that the resident required an identified level of assistance for specified activities of daily living.

The resident's plan of care at the time of the incident indicated that the resident required specified interventions when staff were providing care.

On a specified day, staff member #123 provided care to the resident with an identified level of assistance.

The home's documentation identified that staff member #123 said that they did not provide the required level of assistance required for care to the resident.

The resident sustained an identified injury as a result of the care provided.

The licensee has failed to ensure that care set out in the plan of care for resident #008

was provided by staff as specified in the plan.

b) The licensee has failed to ensure that the plan of care for resident’s #002, #004, and #011 was provided as specified in the plan.

A complaint was submitted to the Director for resident #001 stating that the resident required an identified treatment and alleging that on several occasions, the resident was not receiving the treatment. The complainant also stated that when the resident was not receiving the treatment, the resident's health was negatively impacted. Resident #002 was substituted for this resident.

Record review of orders in Point Click Care (PCC) for resident’s #002, #004, #011 documented that all three residents were to be receiving the identified treatment.

Staff member #102 confirmed that resident #002 was not receiving the identified treatment as prescribed.

Staff member #102 stated that they checked to ensure that resident's were receiving the identified treatment as prescribed once per shift and that they had planned on checking later that day.

On a specified date, residents #004 and #011 were observed to ensure they were receiving treatment as prescribed. Staff member #105 acknowledged that the identified treatment was not being provided to the residents.

Staff member #105 stated that resident’s #004 and #011 were supposed to be receiving the identified treatment at all times. They said that the registered nurse on duty was responsible for ensuring that the equipment was in working condition.

There was no documentation to support that the identified treatment had been checked each shift as required; therefore, staff member #105 and #106 said that they were unable to determine if the equipment had been checked.

Staff member #113 stated that when a resident was prescribed the identified treatment, they should be receiving this treatment uninterrupted. They also stated that the nurse on duty was responsible for ensuring that the equipment had sufficient supply levels, but that there was no documentation of when they were last checked.

Staff members #102, #105, #106, and #113 all stated that it was the responsibility of the night shift to ensure that the equipment was in working condition.

The licensee has failed to ensure that an identified treatment was provided to resident's #002, #004, and #011 as specified in their plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that when resident #009 was reassessed and the plan of care was revised because care set out in the plan had not been effective, that different approaches were considered in the revision of the plan of care s. 6. (11) (b).

a) A CIS report was submitted to the Director related to a fall sustained by resident #009, that resulted in transfer to hospital where the resident was diagnosed with an injury.

A review of the resident #009's falls history documented that they had a history of falls that resulted in identified injuries. Their certificate of death documented an identified cause.

Review of the Fall Risk Assessment documented that resident #009 was an identified risk for falls and had not been updated for five months, despite having continued to have falls during that time.

Staff member #109 stated that resident #009 had identified behaviours that contributed to falls. Staff member #107 said the resident had an identified falls risk and history. They said that the identified falls interventions in place were not effective.

Resident #009's plan of care in PCC related to falls prevention management documented that falls prevention interventions were initiated on a specified date, and no revisions were made until months later when the resident had sustained a fall that resulted in an injury.

Resident #009's plan of care was not updated until they received an identified injury, despite the interventions being ineffective.

Staff member #110 said that they had a falls prevention program in the home and identified residents would be referred. Their falls committee would update a residents plan of care with new interventions based on their analysis. They also stated that although the falls report was completed monthly, the home was able to monitor falls on a daily basis.

Staff member #109 stated that resident #009 had identified injuries as a result of a fall.

Staff member #111 stated that resident #009 had a history of falls prior the fall that resulted in injury, and that the home's falls program should have reviewed their falls and updated their care plan. Staff member #111 confirmed that resident #009's fall prevention interventions had not been revised until they had sustained an identified injury and that the resident's falls intervention strategies were not revised as per the home's usual process.

b) Record review documentated that resident #012 had an identified history of falls.

Review of the resident's care plan related to falls prevention and management interventions showed that no new approaches were considered in the revision of the plan of care in this five month period.

c) Record review conducted showed that resident #010 had an identified history of falls.

Resident #010's plan of care related to falls prevention and management interventions showed that no new approaches were considered in the revision of the plan of care in a five month period.

Staff member #111 confirmed that there were no revisions to resident #010 and #012's fall interventions in the previous five months.

The licensee failed consider different approaches in the revision of the plan of care of resident's #009, #010, #12 and when care set out in the plan had not been effective. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident is reassessed and the plan of care is revised because care set out in the plan has not been effective, that different approaches are considered in the revision of the plan of care s. 6. (11) (b), to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #005 was protected from physical and verbal abuse by PSW #112.

Ontario Regulation 79/10 s. 2 (1) defines physical abuse as, “the use of physical force by anyone other than a resident that causes physical injury or pain”, and verbal abuse as, “any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident”.

A CIS report was submitted to the Director alleging physical and verbal abuse of resident #005 by staff member #112.

Video footage was reviewed. The video footage identified staff member #112 providing care to resident #005 that was physically and verbally abusive on two occasions.

The video footage showed that resident #005 was negatively impacted by staff member #112. The home had identified injuries as a result of the incident.

The home's documentation said that resident #112 admitted to the incidents. Identified disciplinary action toward staff member #112 was also documented.

The licensee has failed to ensure that resident #005 was protected from by staff member #112. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

Issued on this 7th day of February, 2020

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KATHERINE ADAMSKI (753)
Inspection No. / No de l'inspection :	2020_738753_0001
Log No. / No de registre :	021021-19, 021457-19, 021535-19, 021881-19, 022391-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 28, 2020
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village of Riverside Glen 60 Woodlawn Road East, GUELPH, ON, N1H-8M8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bryce McBain

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To Schlegel Villages Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s.6 (7) of the LTCHA.

Specifically, the licensee shall ensure that:

a) resident's #002, #004, #011, and all other residents with an identified treatment, are administered the treatment as specified in their plan of care.
b) a process is developed and implemented to monitor and track the identified treatment provided to residents. This process must be documented and identify the staff responsible for completing.
c) all residents receive the required level of assistance for care specified in their plan of care.

Grounds / Motifs :

1. The licensee has failed to ensure that care set out in the plan of care was provided to resident #008 as specified in the plan.

A Critical Incident System (CIS) report was submitted to the Director related to resident #008 sustaining an injury.

Record review of the resident's Minimum Data Set (MDS), showed that the resident required an identified level of assistance for specified activities of daily living.

The resident's plan of care at the time of the incident indicated that the resident required specified interventions when staff were providing care.

On a specified day, staff member #123 provided care to the resident with an

identified level of assistance.

The home's documentation identified that staff member #123 said that they did not provide the required level of assistance required for care to the resident.

The resident sustained an identified injury as a result of the care provided.

The licensee has failed to ensure that care set out in the plan of care for resident #008 was provided by staff as specified in the plan.
(753)

2. The licensee has failed to ensure that the plan of care for resident's #002, #004, and #011 was provided as specified in the plan.

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The licensee has failed to ensure that an identified treatment was provided to resident's #002, #004, and #011 as specified in their plan of care. [s. 6. (7)]

The severity of this issue was determined to be a level 3 as there was actual harm to a resident. The scope of the issue was a level 3 as it related to four of six residents reviewed. The home had a level 3 history as they had previous non-compliance to the same subsection of the LTCHA that included:
• compliance order (CO) #001 issued July 17, 2017, with a compliance due date of September 30, 2017, (2017_263524_0009);
• voluntary plan of correction (VPC) issued July 31, 2019, (2019_545147_0006);
• VPC issued September 17, 2019, (2019_750539_0014).

(753)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 17, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 28th day of January, 2020

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Katherine Adamski

Service Area Office / Bureau régional de services : Central West Service Area Office